Testimony
Senate Bill 1022, An Act Concerning Telehealth
House Bill 5596, An Act Concerning Telehealth
Insurance and Real Estate Committee
Public Health Committee
March 15, 2021

Senator Lesser, Representative Wood, Senator Abrams, Representative Steinberg, and distinguished members of the Insurance and Real Estate Committee and the Public Health Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS), the Connecticut Urology Society, the Connecticut Dermatology & Dermatologic Surgery Society and the Connecticut Society of Eye Physicians, thank you for the opportunity to provide this testimony to you today on Senate Bill 1022, An Act Concerning Telehealth and House Bill 5596, An Act Concerning Telehealth.

The Covid-19 pandemic has exploded the use of telehealth. Faced with lockdowns and public health concerns, physician offices in Connecticut quickly and efficiently turned to telehealth to be able to care for their patients in the midst of this crisis. As we begin to look beyond the Covid-19 pandemic, the use of telehealth becomes and remains an increasingly important part of medical care moving forward.

The current pandemic has provided a crash course for many physicians and patients on the use of telehealth. Many of the obstacles to telehealth, particularly in infrastructure, have already been overcome by necessity during the Covid-19 pandemic. Early studies are showing that prior to the Covid-19 pandemic, patient sentiment for telehealth was tepid, but patients now are embracing and in fact requesting telehealth visits where appropriate.

The pandemic has highlighted existing racial, economic, and geographic disparities that can hinder access to medical treatment. Telehealth has the potential to improve access to care for marginalized groups faced with challenges of limited resources and limited access to care. Telehealth can save money and time for those who do not have access to reliable transportation, have childcare responsibilities or cannot take time off work. The reality is that many patients may not feel comfortable in a health care setting and would rather get care on their own terms.

There are two bills before the Committees today: House Bill 5596 and Senate Bill 1022. SB 1022 contains significant improvements to the telehealth statutes, but also presents some troubling language. HB 5596 does not yet have language beyond concepts.

The changes proposed to Connecticut General Statutes §38a-499a(b) and Section 5 of SB 1022 present important changes in facilitating telehealth throughout Connecticut. Proposed revisions to Connecticut General Statutes §38a-499a(b) requires that insurers provide coverage for medical advice, diagnosis, care or treatment through telehealth to the same extent such services are provided in-person. This ensures that services that would be covered if offered during in-person visit would also be covered if provided through telehealth. This is not a mandate to cover new services, but rather a requirement to cover services regardless of whether those services are delivered in-person or through telehealth modalities.

However, coverage alone is not sufficient for facilitating an expansion of telehealth, as many insurers have historically covered select telehealth services, but have reimbursed physicians at a significantly reduced rate compared to rates for the same services provided in-person. Section 5 of SB 1022 extends parity in payment to telehealth services. We applaud the Insurance and Real Estate Committee for including this provision in SB 1022 and recognizing the critical need for telehealth payment parity. With many studies demonstrating comparable quality for medical services provided via telehealth and in-person, the reimbursement should not be substantially reduced simply because of a different delivery modality. Reduced telehealth rates are not sustainable and do not cover the overhead costs of the technology nor the physician time. Physicians must have the flexibility to decide whether to see their patients via telehealth or in person without unnecessary pricing incentives. In addition to standard office expenses such as staffing, office expense and malpractice insurance, practices engaging in telehealth can expect to see additional expenses for:

- Telehealth software and supporting equipment (monitors, cameras, digital exam tools),
- Staff and physician telehealth training,
- Additional staff time assisting patients with technology challenges,
- Enhanced security,
- Remote patient monitoring tools,
- Telehealth-specific policies and procedures,
- Supplemental telehealth patient-education materials,
- Expanded internet bandwidth.

Section 1 of SB 1022 and the amendments to Connecticut General Statues §19a-906(b) set forth under what circumstances a telehealth provider can provide telehealth services to a patient. Section (b) of amended 19a-906 would, in part, require the telehealth provider to determine whether the patient has health coverage that is fully insured, not fully insured and the coverage, if any, for the telehealth service. In theory, these may appear to be reasonable requirements, in reality, however, this presents physicians with an impossible task. Patient insurance cards do not specify whether the patient's insurance is fully insured or self-funded. In fact, patients often do not know the type of coverage they have. When employers contract with commercial insurers under an Administrative Services Only plan (ASO or self-funded model), the commercial insurer becomes the administrator of the plan. The insured receives a card from the commercial insurer that looks on its face as if the plan is a fully insured model, when in reality the insurer is only serving as the network administrator under the ASO arrangement.

We have been before this legislature numerous times asking for legislation that would require insurance cards to identify whether the coverage is fully insured or self-funded. Absent this requirement, physicians have no way of identifying at the point-of-care the type of coverage provided and we would strongly recommend this requirement be removed from SB 1022. Without the removal of this language, very few physicians would actually be able to provide telehealth services under the limitations presented by the revised statute.

Similarly, physicians are not always able to determine at the point-of-care what coverage an insurer or a self-funded employer provides for telehealth services. It should be incumbent upon the health insurance industry to find a mechanism to provide this information to physician offices at the point-of-care. As this is often out of the control of physician practices, we would again ask that this requirement be removed from SB 1022.

SB 1022 allows for audio-only telehealth visits for in-network physicians. This is an important component of telehealth. While the video module allows for human connection, it does not always enhance clinical care. For patients with chronic conditions such as congestive heart failure or diabetes, reviewing lab results, vital signs and the patient's medical history play a large part in the clinical decision making. The video component of these discussions is not always critical to deliver high-quality care through telehealth. Audio only telehealth is especially critical for behavioral health services and where increased access is vital for at-risk and underserved populations.

The revisions proposed to Connecticut General Statutes §19a-906(h) in SB 1022 state that if a telehealth provider determines that a patient does not have health coverage for such health services provided by telehealth, the provider shall accept Medicare reimbursement in full satisfaction of the telehealth services provided. As noted above, physicians cannot always determine coverage at the point-of-care- the insurers are the only ones equipped with this level of information. As such, we would ask that the language be amended to indicate that the reimbursement will be at the in-network rate. How can it be incumbent upon physicians to determine coverage when they simply do not have robust point-of-care access to the information that the health insurers do? This section would financially penalize physicians for not having access to this data. Physicians would have to know every detail of a telehealth visit in advance to be able to ascertain whether the telehealth service would be covered which is an unrealistic expectation. In addition, the sheer amount of administrative time that would be spent on determining such coverage would place a tremendous burden on physician offices and detract from the time spent providing patient care.

We would be remiss if we did not discuss a potential pitfall in telehealth: the expansion of the for-profit corporate telehealth companies. Corporate telehealth companies often market themselves to Connecticut patients as a quick and inexpensive way to get medical treatment without going to your primary care doctor. The result is fragmented medical care which is not beneficial for patients or physicians. When medical care is provided outside of the medical home, important medical information does not make its way into the patients' medical records. This could potentially present a dangerous medical situation for patients who may, for example, be prescribed an antibiotic from a telehealth provider outside of the medical home that reacts with medication the patient is already taking. In addition, the patient's treating physicians may never know the patient was ever prescribed the antibiotic. This is the definition of fragmented care. It presents potentially dangerous medical situations for patients and is more costly to the entire medical system as the treating physicians may need to re-treat or re-examine a condition that was already "treated" via telehealth outside of the medical home.

SB 1022 would allow a significant number of out-of-state providers to become telehealth providers. While we recognize that many times telehealth health will need to be provided across state lines, opening the flood gates to out-of-state providers does not seem like the best solution. Questions arise such as which standard of care will be followed: Connecticut or the other state? Which state will have jurisdiction over medical malpractice claims? How will the Department of Health or the Medical Examining Board track and respond to complaints regarding out-of-state physicians?

In order to prevent fragmented care, we would recommend SB 1022 and HB 5596 prohibit health insurers from establishing or contracting with separate telehealth networks that do not include the insurers own in-network physicians. Further, we would recommend that language be included that prohibits insurers from adopting cost-sharing structures that incentivize or steer patients to these corporate telehealth networks- in-network telehealth providers must be paid at their contracted rates, which under SB 1022, would require parity between telehealth and in-person rates. Connecticut cannot

allow out-of-state corporate telemedicine networks to come in and take over patient care. Facilitating access to telehealth services by in-state providers will not eliminate, but it would certainly help ameliorate some of the very real concerns that we have with the proliferating commercial telehealth companies that offer discounted, but fragmented care, including the growing adverse impact of non-professional ownership and direction of care, the risk of further loss of independent physicians, issues of standard of care and the proper jurisdiction and adjudication of patient complaints and lawsuits.

We urge this legislature to take an important step forward in improving the access and value of medical care provided to Connecticut's patients by adopting comprehensive telehealth legislation that ensures coverage and parity in reimbursement for services provide by telehealth. We would be happy to work with members of both the Insurance and Real Estate Committee and the Public Health Committee in amending SB 1022 and drafting HB 5596. Thank you.